

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2012
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HADLEY RD MOORESVILLE, IN 46158		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one State hospital complaint.</p> <p>Complaint Number IN00105159 Substantiated; no deficiencies cited.</p> <p>Survey Date: 9-26-2012</p> <p>Facility Number: 005052</p> <p>Surveyor: Deborah Franco, RN Public Health Nurse Surveyor</p> <p>Franciscan St. Francis Health-Mooresville was found in compliance with 410 IAC 15-1.4-1, Governing body, Hospital Licensure Rules.</p> <p>QA: cloughlin 09/28/12</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1